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Editorial by Michael Ross for The Clinical Teacher, April 2016 issue

Everyone seems to be talking or writing about empathy. There is general consensus that good clinicians demonstrate it, and that we should help students and trainees develop it.[1] There is also increasing understanding of the underlying social psychological and neurobiological mechanisms.[2, 3] However, although over a hundred years have passed since Tichener introduced 'empathy' into the English language, we still lack a common understanding of the concept and its implications for clinical teaching.[1, 4] When asked by medical students, in this issue, "What kind of doctor would you like me to be if you came to me with an illness?", most patients emphasised 'personal qualities' including empathy and also communication skills.[5] A minority emphasised knowledge and intelligence, but none emphasised manual skills. A recent systematic review in general practice (family medicine) found that increased physician empathy seems to lower patient anxiety and distress, improve patient satisfaction and enablement (confidence and ability to cope with life and illness), and improve clinical outcomes such as diabetic control.[4] The authors described empathy as the ability of a physician, "To understand the patient's situation, perspective and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way".[4]

As well as defining and differentiating empathy from related concepts such as 'sympathy' and 'patient-centredness', much of the clinical education literature describes or applies instruments to try and measure it.[2, 6] One systematic review identified 36 different instruments, eight of which demonstrated sufficient reliability, internal consistency and validity to study empathy in clinical care and training.[6] Most were only self-reported measures however, and the authors felt none had sufficient predictive

validity to recommend their use in selecting applicants for training. Using such instruments, potential associations have been identified between empathy and gender, ethnicity, speciality choice, risk of being sued for malpractice and susceptibility to burnout.[1, 7] A systematic review also found that after a possible initial increase, empathy seems to decline during medical school and speciality training, with potential contributing factors including unrealistic expectations, mistreatment by superiors, high workload, lack of support and unsuitable learning environments.[7]

Many strategies to help clinicians develop empathy have been described in the literature. A recent systematic review identified fifteen studies of interventions with medical students which seemed to be effective in this, although most involved pre-post intervention comparisons and the authors highlighted a need for larger, more rigorous longitudinal studies.[1] The interventions included creative arts around patient narratives, drama, reflective writing, training in communication and interpersonal skills, problem-based learning, patient-interviewing tasks and simulation. Many other interventions seem likely to influence clinician empathy but require more research - for example in this issue student placements in deprived and underserved general practice and community settings,[8] and having students undertake everyday activities whilst wearing a suit that simulates functional impairments.[9]

Each issue of *The Clinical Teacher* contains 'Digest' and 'In Brief 'articles, which summarise recent articles likely to be of interest to clinical teachers from our sister journal *Medical Education* and from other sources respectively. A Digest in this issue summarises a systematic review comparing how researchers have defined (conceptualised) and measured empathy in medical education.[10] The review identified 109 articles, most of which included a definition of empathy incorporating two or more of the following three elements: thinking (cognitive); feeling (emotional); and acting

(behavioural, including communication).[11] These elements of the definition related closely to those identified in the instruments used to measure empathy in only 13% of studies. In other words, for most quantitative studies on empathy, researchers do not seem to be measuring what they think they are measuring. As we develop our understanding of the important elements of empathy in clinical practice and education, we are likely to want ever-more sophisticated ways to assess and study them. David Jeffrey, for example, conceptualises empathy as a two-way relationship with many more context-dependent elements, including developing a reciprocal connection with the patient, being emotionally-engaged yet able to differentiate your own emotions from theirs, being curious to learn about the patient's perspective and experience, and acting dynamically and ethically with care, concern and humility.[12]

At a recent local medical education meeting we were struck by similarities between our research on student empathy and aspects of our ongoing work on faculty development and student evaluation of teaching. A national survey of clinical teachers suggested that many do not feel recognised, valued or supported in their educational roles, with one respondent writing, "The band of overworked, stressed and overstretched clinicians are your customers – you need to treat them with respect, cultivate them and really listen to them''.[13] The teachers seem to have perceived a lack of empathy in their relationship with those responsible for the training programmes. We are now studying this in more depth and exploring how medical school communication and management practices might affect the experiences and perceptions of clinical teachers.

Although much of the research on clinician empathy has been undertaken in medicine, the issues seem to be common across the healthcare disciplines. Students and trainees frequently report that they do not feel sufficiently understood, valued and supported, and there is a substantial and disturbing body of literature on student and trainee

discrimination, harassment and abuse in clinical education.[14] We know that some forms of intimidation and harassment may be viewed by those involved as useful educational tools – especially if perceived to have an acceptable purpose, to be necessary in the situation and to have positive clinical or educational outcomes.[14] Yet they are likely to have a negative influence on empathy development.[7] How can we expect learners to develop empathy if they are not treated with empathy themselves? The key attributes of a good clinical teacher, as perceived by medical students in this issue, include being able to develop rapport and relate to students in addition to role-modelling rapport and empathy with patients.[15] Empathy seems to be just as important in the teacher-learner relationship as it is in the clinician-patient relationship, and indeed in the relationship between teachers and their colleagues. After all, who wouldn't want to be valued, understood and treated with respect – irrespective of whether we are currently learning, teaching or sick?

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